A BRIEF

SUBMITTED TO THE

MEDICAL SERVICES INSURANCE ENQUIRY

BY THE

ONTARIO MEDICAL ASSOCIATION

DECEMBER 1963

MEDICAL SERVICES INSURANCE ENQUIRY

Public Hearings, Toronto

Appearing for the Ontario Medical Association

(Canadian Medical Association, Ontario Division)

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PART I

SUMMARY AND RECOMMENDATIONS

SUMMARY

(i) The Ontario Medical Association is an incorporated voluntary organization with some seven thousand members from all branches of medicine and all geographic areas of the province.

(ii) Our members have been associated, for many years, with the development and operation of some insuring agencies and, as the providers of medical services, they have had close contact with subscribers of all carriers. This unique experience has provided the background for this submission.

(iii) We agree with the basic principles of Bill 163, and believe that the implementation of legislation based on them will meet the requirements of Ontario residents.

(iv) The recommendations contained in our submission have been made after serious consideration. We believe them to be sound in principle, practical and acceptable in application.

(v) We appreciate the magnitude of the task assigned to you as commissioners of this Enquiry. On behalf of our members, we thank you for this opportunity and privilege of placing the views of our Association before you. We trust they will be of some assistance as you complete your deliberations.

RECOMMENDATIONS

The Ontario Medical Association recommends:

1) THAT there be three standard medical services insurance contracts which, for purposes of clarity, might be named:

   i) Standard - with benefits of Schedule A and first dollar coverage.

   ii) Standard Deductible - with benefits of Schedule A and a defined deductible and co-insurance factor.

   iii) Standard In-Hospital - with benefits of Schedule B and first dollar coverage. (paras. 15, 180, 181, and 182)

2) THAT carriers be required to offer the Standard In-Hospital and either the Standard or Standard Deductible contracts. (paras. 13 and 184)

3) THAT the benefits of Schedule B be enlarged to include out of hospital referred consultations and diagnostic services within the limits suggested. (para. 164)

4) THAT the benefits and exceptions of Schedule A be modified as outlined. (para. 131)

5) THAT a carrier be permitted to issue contracts other than standard contracts but where a carrier issues one of the standard contracts, it be permitted by rider to the contract for an additional stated premium and not otherwise, to provide benefits greater than those set forth in Schedules A and B. (paras. 19 and 185)

6) THAT all groups of self-insurers be required to be licensed under this Act and to become and remain members in good standing in Medical Carriers Incorporated; THAT this type of carrier should not be authorized or compelled to issue standard contracts to the general public. (paras. 26 and 184)

7) THAT the bill state more specifically the purposes and objects of Medical Carriers Incorporated; THAT these be confined to matters of a technical nature including the administration of a pooling arrangement. (paras 98 and 187)

8) THAT the Bill establish an Advisory Committee to act as an adviser to the Minister relative to the operation of the initial legislation and whatever changes may be required to fulfill the purposes of Bill 163; THAT its membership, method of appointment, and its purposes and objects be set out in the Act. (paras. 100 and 188)

9) THAT the Minister, on the recommendation of the Advisory Committee, be authorized to suspend or cancel the licence of any carrier if he deems that it is not operating in the public interest or if it contravenes any provision of this Act. (paras. 29 and 186)

10) THAT a per diem penalty be imposed on any carrier that carries on business as such without a licence under this Act. (paras. 30 and 186)

11) THAT the amounts of benefits payable under standard contracts be set out more specifically in Section 17. (paras 31 and 191)

12) THAT the persons given total subsidy be those in needy circumstances in the classes listed in Schedule C. (para. 48)

13) THAT, for those totally subsidized:

1) Government insure the benefits of Schedule A on a basis of first dollar coverage.

2) Government make an arrangement with the Ontario Medical Association for the insurance of this group.

3) This arrangement be outside of Medical Carriers Incorporated. (para. 83)

14) THAT those residents whose incomes do not exceed their personal exemptions on the TD 1 income tax form and who either do not meet the requirements for total subsidy or choose not to apply for same, be made eligible for a partial subsidy; and THAT those eligible for partial subsidy be detailed in a separate schedule in the Act. (paras. 48 and 49)

15) THAT the subsidy provided to, or on behalf of, those requiring partial assistance, be a fixed-dollar amount not to exceed the amount of the premium. (paras. 60 and 63)

16) THAT any subsidy be made available only for the purchase of the Standard Medical Services Insurance Contract. (para. 72)

17) THAT the individual, applying for partial subsidy, make a statutory declaration of his eligibility for subsidy, to the carrier of his choice, and that the carrier bill government on behalf of all subsidized residents to whom it had issued Standard contracts. (para. 65)

18) THAT all subsidized medical services insurance contracts bear some mark or code which will make it apparent to the doctor that the patient is in receipt of subsidy. (para. 87)

19) THAT section 54 of the Public Health Act be repealed; and that this legislation place upon the municipality the responsibility for the insurance or payment of medical services, required by needy residents, analogous to that placed upon it by the Hospital Services Commission Act and the regulations thereunder. (paras. 91 and 96)

20) THAT the board of arbitration referred to in section 18 (2) be changed so that:

1) Medical Carriers Incorporated name one arbitrator.

2) The second arbitrator be named by the Minister.

3) The third arbitrator, who shall be chairman, be appointed by a judge of the Supreme Court. (paras 114 and 192)

21) THAT a new section be enacted, reading as follows:

> "No carrier, by a medical services insurance contract, shall interfere with the right of an insured person to choose his own physician or impose an obligation upon a physician to treat any insured person."

(paras 118 and 194)

22) THAT the insurance of all medical services be brought under the provision of a Medical Services Insurance Act; THAT this policy be established now and implemented as soon as possible: and THAT in the meantime no further encroachment be allowed by further amendment to the regulations under the Hospital Services Insurance Act. (para. 144)

23) THAT the suggested amendments to Bill 163, set out in Part II of this submission, be incorporated in the Act. (paras. 167 to 195)

24) THAT government give early consideration to a plan whereby subsidized patients will be assured of getting necessary drugs. (para. 148)

25) THAT preoccupation with medical services insurance not delay the provision of government funds for medical schools, medical teaching, schools of nursing, hospital beds and the other facilities and personnel required to maintain a high standard of medical services. (para. 130)

B R I E F

from

ONTARIO MEDICAL ASSOCIATION

to

MEDICAL SERVICES INSURANCE ENQUIRY

1963

RE: AN ACT RESPECTING MEDICAL SERVICES INSURANCE, BILL NO. 163, INTRODUCED AT THE 1962-63 SESSION OF THE ONTARIO LEGISLATURE

1. The general conclusion to the Code of Ethics of the Canadian Medical Association, to which our Association subscribes, contains these words:

> "The complete physician is not a man apart and cannot content himself with the practice of medicine alone, but should make his contribution, as does any other good citizen, towards the well-being and betterment of the community in which he lives."

2. In keeping with this admonition, the Ontario Medical Association, on behalf of its seven thousand members, is pleased to accept your invitation to present some opinions about medical services insurance in general, and the principles enunciated in Bill 163, in particular.

3. We wish to state at the outset that we are in general agreement with the principles embodied in Bill 163, whereby:

1) Government sets a standard of benefits for a comprehensive contract and for a limited contract.

2) Carriers are required to make these contracts available to every resident, and yet no resident is compelled to purchase them.

3) There is no exclusion of carriers from the field, provided they meet the reasonable requirements of the Bill.

4) Carriers are required to guarantee that these contracts cannot be cancelled except for reasons stated in the Bill.

5) Carriers are forbidden to charge any resident applying for a standard contract more than the maximum premium provided for in the Bill.

6) Government is committed to purchase or contribute to the purchase of comprehensive contracts for those residents requiring such assistance.

7) Subscribers have free choice of carrier and physician.

4. We believe these principles provide a nice balance between private initiative and personal responsibility on the one hand, and government supervision and communal responsibility on the other.

5. In our presentation to the Royal Commission on Health Services in May 1962, (copy attached,) we stressed our belief in the evolutionary approach to the solution of problems relating to medical services and medical services insurance. It is our view that the introduction and discussion of Bill 163 in the legislature, and its subsequent referral to this public enquiry, have acted as a catalyst to the evolutionary changes which have been

taking place in the field of medical services insurance, particularly in the last twenty-five years.

6. We believe the major responsibility of the commissioners of this enquiry will be to offer to government some advice as to how the principles outlined in Bill 163 can be implemented. In this connection, the recommendations contained in our submission should be worthy of your serious consideration, the members of our Association having been in the unique position of having had many years of day to day experience with the many facets of medical services insurance.

7. Our members have been the providers of medical services insured by all plans and as such have been in a preferred position to assess patient reaction to the myriad of insurance mechanisms in vogue from time to time. They stimulated interest in medical services insurance by initiating plans with comprehensive benefits and have continued to advise and support those plans. They have administered the Medical Welfare Plan continuously since 1935. (Appendix I) It is against this background of broad experience that we portray the views of our Association on this important subject.

8. This brief is divided into two parts. Part I deals with what we deem to be matters of principle and policy. Part II deals with details of the Bill to implement certain of the matters discussed in Part I, and to clarify certain minor points.

PART I

STANDARD CONTRACTS

9. Later in our submission we will make specific recommendations relating to the benefits of Schedules A and B. At the moment we will confine our discussion to the number and variety of standard contracts which it might be reasonable to use in making the benefits of the schedules available with the protection of a maximum premium and a non-cancellability provision.

10. An examination of the normal business practices of the carriers, now licensed in the province, revealed that some provide benefits only on a basis of first dollar coverage, others only with deductibles and/or co-insurance, and some on both bases.

11. The corollary is that, while there is a trend toward first dollar coverage, there is still a significant number of citizens who wish to use insurance only as a hedge against the catastrophic element of large and unexpected medical services costs.

12. With these facts in mind, we gave consideration to the best method of integrating the desires of the public and the normal business practices of the carriers into sound and acceptable proposals.

13. We concluded, and we think correctly, that the problem would be solved if the benefits of Schedule A were made available by every carrier on a basis of first dollar coverage OR with defined deductible and co-insurance

provisions, and the benefits of Schedule B, were made available by every carrier on a basis of first dollar coverage.

14. We are confident that if this recommendation was adopted, every resident would be able to purchase a type of contract to fit his particular requirements and at the same time have the protection of a standard contract.

15. In essence, we are proposing

THAT there be three standard contracts which, for purposes of clarity, might be named:

1) STANDARD MEDICAL SERVICES INSURANCE CONTRACT

This would provide the benefits set forth in Schedule A, and be sold on a basis of first dollar coverage.

2) STANDARD DEDUCTIBLE MEDICAL SERVICES INSURANCE CONTRACT

This would provide the benefits set forth in Schedule A, subject to a deductible of $25. per annum, ($50. per annum per family,) and subject to a co-insurance requirement that the subscriber bear 20% of each claim for benefits above the deductible.

(Note: If thought advisable, the liability of the subscriber for the co-insurance factor could be limited to a reasonable amount.)

3) STANDARD IN-HOSPITAL MEDICAL SERVICES INSURANCE CONTRACT

This would provide the benefits of Schedule B on a basis of first dollar coverage.

16. The implementation of this recommendation will require amendments to certain sections of the Act. These will be detailed in Part II of our submission.

SCOPE OF THE ACT

17. It would appear that the intent of the Act is to permit the issue of medical services insurance contracts other than standard contracts by carriers provided,

a) that the carriers offer the standard contracts as well; and

b) that the carriers are members of Medical Carriers Incorporated.

18. Having regard to the definitions in clauses (b) and (i) of section 1 and section 6, there may be some slight doubt as to the Bill making this intent clear, although section 5 is fairly precise. Perhaps the matter might be settled by an amendment to section 6 to make it clear that a carrier is permitted to issue, in conjunction with a standard plan, a contract that provides greater benefits, so long as this does not conceal the premium of the standard plan.

19. We suggest, therefore, that section 6 be amended to read as follows:

> 6. Where a carrier issues a standard medical services insurance contract, or a standard deductible medical services insurance contract, or a standard in-hospital medical services insurance contract, it may, by rider to the contract for an additional stated premium and not otherwise, provide benefits greater than those set forth in Schedules A and B.

SELF-INSURERS

20. There is a situation existing presently in the province where the members of an organization arrange with one or more physicians to render medical services to the members and their dependents. This arrangement may be on the basis of a monthly fee per member, or of a salary paid by the organization to the physician.

21. This situation poses problems to the purposes of this legislation. If persons, firms, groups, associations, societies, unions, agencies, and corporations are allowed to continue to sell what amounts to medical services insurance to selected risks only, they will be avoiding the obligations imposed on carriers licensed under the Insurance Act, or under the Prepaid Hospital and Medical Services Act, to carry their proportionate share of the extra cost required to insure the aged and the chronically ill. This is not only manifestly unfair, but could result in anti-selection against these licensed carriers and make the Bill unworkable.

22. It would seem logical, therefore, that all such groups of self-insurers should be required to be licensed under this Act, and to become and remain members in good standing of Medical Carriers Incorporated. They would then be subject to pooling unless they could show they were carrying their fair share of the high cost risks. In such cases, a temporary exemption from participation in pooling might be granted pursuant to the by-laws of Medical Carriers Incorporated.

23. However, if they become members of Medical Carriers Incorporated and "carriers" under the definition of this Act, then they would normally be required to provide standard contracts of insurance to anyone who applied for it. It seems almost impossible to relate specifically the benefits contemplated as payable under Schedules A and B to their situation, and method of operation.

24. Further, these organizations would, under the laws of Ontario, be required to be incorporated, and would also have to possess charter powers either to undertake accident and sickness insurance contracts under the Insurance Act, R.S.O. 1960, Chap. 190, or prepayment contracts under the Prepaid Hospital and Medical Services Act, R.S.O. 1960, Chap. 304.

25. There is little doubt that the definition of "carrier" in clause (b) of section 1, and the definition of "medical services insurance" in clause (i) of section 1 of the Bill as presently worded, do apply to contracts beyond the scope of insurers licensed under the Insurance Act, and associations registered under the Prepaid Hospital and Medical Services Act.

26. We would conclude it to be a sound principle that the above definitions should stand, so that all such groups would be required to become and remain members in good standing of Medical Carriers Incorporated. Further, that this type of carrier should not be authorized or compelled to issue standard contracts to the general public, i.e., insofar as their

plans and arrangements are concerned they should be excluded from the absolute provisions of section 5 (a). Otherwise, in the public interest, they would have to be subjected to the same sort of governmental regulations and supervision as is now provided in respect to licensed insurers and registered associations.

27. In Part II we have set out amendments and additions to section 5 to incorporate these recommendations.

SUSPENSION AND REVOCATION OF CARRIER'S LICENCE

28. While section 7 (1) requires a carrier to hold a licence, once having obtained this it stays in force subject to the automatic termination provided in section 19 (2).

29. We believe that it is advisable that the Minister should have some disciplinary powers in the event that a carrier carries on business in a way contrary to the public interest. We, accordingly, suggest that sub-section (2) of section 7, be renumbered as subsection (3) and that a new subsection be added as follows:

> (2) The Minister, on the recommendation of the Advisory Committee, may suspend or cancel the licence of a carrier if he deems that it is not operating in the public interest or if it contravenes any provision of this Act.

30. As we are here dealing with section 7, we suggest that the penalty provided by renumbered subsection (3) is inadequate. We believe that a per diem penalty should be imposed upon any carrier who contravenes the section.

BASIS OF BENEFITS - SECTION 17

31. We do not believe that this section states clearly the amount of the benefits to be provided under the standard plans. We believe the intention is to have the benefits paid according to the fees set forth in the schedule of fees of the Ontario Medical Association. We agree with this interpretation. At the same time we are cognizant of the desire of government to disturb the present business practices of carriers as little as possible.

32. It is well known that certain carriers, sponsored and controlled by the medical profession, have entered into participating physicians' agreements with the majority of physicians in their area of interest whereby they agree to accept conditions of payment as set out in the agreement with the carrier. It is equally well known that not all physicians participate with those carriers because of a preference to deal directly with their patients. Bill 163 should provide for both situations.

33. We believe, however, that subscribers who exercise their free choice of physician by going to non-participating physicians, either in or out of the province, should be indemnified in accordance with the fees set forth in the schedule for the benefits of standard contracts.

34. Our Association's schedule of fees is a differential schedule, i.e., it lists fees for practice in general, and fees for certified specialists.

35. While we believe that certified specialists should be free to charge the fees listed in the specialists' column of the schedule, to any or all patients treated by them, we are of the opinion that the benefits of the standard plans should be satisfied by payment of specialists' fees in those situations where a patient is referred to a specialist by another physician, or where the only fee listed is in the specialists' column.

36. We advocate this policy because we feel it is the one most likely to assure a continuation of high quality medical services by strengthening the position of both the general practitioner and the specialist, who acts as a consultant.

37. Moreover, this policy does not discriminate, in premium cost, against the subscriber who is satisfied to have specialist services only on the advice of the family physician; the subscriber who lives in an area where specialist services are not readily available; or the subscriber who lives in an area where specialists see only patients who have been referred to them.

38. The changes required in section 17, to incorporate these recommendations, have been detailed in Part II.

39. In discussing this section, we have set down what we consider to be the proper liability of carriers for payment of benefits under the standard plans.

It should not be assumed that the payment of the fees recommended will, in all cases, be considered by those rendering the services as full payment for those services.

40. We believe in the majority of cases it will be. However, it must be remembered that the schedule of fees of our Association is an average schedule for use across the province. Two or three examples will illustrate situations where an appropriate extra-bill would be expected. One is where patients choose to use the services of specialists without being referred for those services; another is when services are rendered by senior members of the profession, who have gained eminence in their area of practice; the third is where the services demanded are, in the opinion of the attending physician, more than necessary for adequate care of the condition.

PROVINCIAL CONTRIBUTIONS - SECTION 3

41. The Act, section 3 (a) and (b), accepts the principle that the government will purchase or contribute to the purchase of medical services insurance for those in needy circumstances.

42. The problem presented here is to define "those in needy circumstances." We have considered this at length and reviewed many approaches. From this study we concluded that those residents who were required to pay income tax should be able to pay their own premium. This conclusion was reached on the basis that if government's present income tax formula

does not leave residents with sufficient moneys to provide the necessities of life, then it should be modified to do so.

43. It then seemed reasonable to conclude that those who did not pay income tax should receive government subsidy. However, further study revealed that there are infinitely varied exemptions which are allowed over and above personal exemptions in determining liability for income tax payments. We are of the opinion that presently many persons, who do not pay income tax because of exemptions, other than personal ones, are able to and do purchase their own medical services insurance. We believe also that a substantial subsidy to those in real need is preferable to a lesser subsidy spread over a wider field.

44. This led to a consideration of the level of personal exemptions on the TD 1 income tax form as a suitable dividing line. We concluded that this was a more practical level because it is administratively simple, and easily understood by the public; because it takes into consideration the number of dependents and makes an additional allowance for persons age 65 and over. Further, this approach lends itself to a simple and easily checked method of application for subsidy.

45. Then assuming that those persons whose incomes are less than their exemptions on the TD 1 income tax form are eligible for government assistance, we considered dividing these as to degrees of assistance.

We studied closely a method of determination which used a formula of income related to these exemptions. We concluded that this was sound in principle but it appeared to be impractical in application.

46. This left us with consideration of dividing government assistance into total and partial subsidy. We concluded that the presently existing machinery for determination used by the Department of Public Welfare had stood the test of time and would have to be continued to screen those requiring financial assistance for the other necessities of life and that these persons as detailed in Schedule C, should be in receipt of total government subsidy. Further, that the persons between this group and the self-sufficient should be in receipt of partial subsidy which should be sufficiently extensive to produce an incentive to insure.

47. This approach is, we believe, practical and easily understood, but like all systems of rough justice, will work a hardship on a few persons in an exceptional financial position. It seems logical that only the local organizations can assess this need, and that, therefore, these particular cases fall within the purview of the municipality.

48. Therefore, we would recommend:

1) THAT the persons given total subsidy be those in needy circumstances in the classes listed in Schedule C.

2) THAT those residents whose incomes do not exceed their personal exemptions on the TD 1 income tax forms and who either do not meet the requirements for total subsidy or choose not to apply for same, be made eligible for a partial subsidy to assist with the purchase of standard medical services insurance contracts.

49. Those persons eligible for total subsidy are set out precisely in Schedule C. We believe, and so recommend

THAT those eligible for partial subsidy should be detailed similarly in a separate schedule in the Act.

THE METHOD OF PARTIAL SUBSIDY

50. Having determined those residents who, in our opinion, should be eligible for partial subsidy by government, we turned our attention to a discussion of the method of subsidy. There appeared to be three methods worthy of consideration:

1) Payment of a percentage of the premium.

2) Payment of a schedule of benefits.

3) Payment of a fixed-dollar amount per category of rate structure.

51. 1) Payment of a Percentage of the Premium

In using this method of subsidy, the initial upper limit of government's financial commitment would be known as it could not exceed the determined

percentage of premium subsidy multiplied by the maximum rate for each eligible person.

52. The exact amount would be known only if the number who would buy insurance was known and if all were directed to insure themselves through a community-rated plan with its uniform premium. This, however, would be at variance with the philosophy of government and our Association, both of which believe in the use of multiple carriers.

53. The subsequent financial responsibility of government would be dependent upon the current premiums charged by all the carriers. Government would either have to pay its percentage of the going rate or place itself in the position of setting rates for each community-rated plan, and each individual premium for the experience-rated plans. This, of course, would be a direct contradiction of its avowed intention not to interfere in the normal business affairs of the carriers.

54. 2) Payment of a Schedule of Benefits

In this method of subsidy, government would determine the amount of money which would be paid to the carrier for each item of service received by each insured person eligible for partial subsidy. This could be done by taking our Association's schedule of fees and assigning the amount of benefit (money) which would be paid for each item or class of item (e.g., office call - home call) in the schedule.

55. Government's initial commitment, per insured person for which it was responsible, would have to be estimated on the basis of current utilization figures for each item of service. Government's subsequent financial responsibility would vary with changes in utilization. The experience of plans with which we are most familiar have shown a rather constant increase of three to four percent per year.

56. The disadvantage of this method, aside from the inability of government to determine, for budget purposes, its commitment in any one year, is the additional administration required. Each carrier would have to keep records of utilization by item of service and bill government on this basis; government in turn would have to pay each carrier each month for each item on the basis of its schedule of benefits.

57. 3) Fixed Dollar Subsidy

In this method of subsidy, government would establish an amount of money which would be paid either to the individual for the purchase of a standard medical services insurance contract, or to the carrier when such a contract is purchased. (We favour the latter approach for reasons which will be developed later in our submission.) The amount of subsidy would be different for each rate structure - single, family, etc.

58. By this method, the initial financial obligation of government would be fixed more definitely. Moreover, it would not change subsequently with changes in premium rate by one, some or all carriers.

59. Changes in the amount of subsidy could be made at a time suitable to government and in a manner which would allow normal budgetary control. Government would not become involved in setting the premiums of carriers and would have no reason to interfere in the normal conduct of business of the carriers. The citizen could take his subsidy and insure himself with the company which would give him the best value for his dollar. This would strengthen the advantages which come from competition in the market-place.

60. Our assessment of these three choices has led us to the recommendation

THAT the subsidy provided to, or on behalf of, those requiring partial assistance, should be by the fixed-dollar method.

THE AMOUNT OF THE PARTIAL SUBSIDY

61. It seems to us that the success of the approach envisioned in Bill 163 depends, in large measure, on getting a high percentage of non-insured residents to buy insurance. This will be true, particularly for those requiring partial subsidy.

62. The amount of the subsidy will likely be the key factor. We believe it should be substantial so as to be an incentive to purchase insurance. For instance, if the average premiums required for the individual standard contract on a universally-available basis turns out to be in the neighbourhood of

Resident ----------	$ 63. per year
Resident and one dependent ----------	$126. per year
Resident and more than one dependent ----------	$160. per year,

then we believe the subsidy should be in the order of:

Resident ----------	$ 45. per year
Resident and one dependent ----------	$ 90. per year
Resident and more than one dependent ---------	$120. per year.

63. In no case would a greater amount of subsidy be paid than the premium cost for which the individual was responsible.

THE MANNER OF PAYING THE PARTIAL SUBSIDY

64. Those requiring partial assistance could be given the appropriate subsidy and allowed to purchase insurance from the carrier of their choice. There are two drawbacks: One, the government would be required to deal with each individual citizen who qualified for subsidy, and secondly, there would be difficulty in checking to make sure the money was spent for the purpose for which it was given.

65. These drawbacks could be eliminated without interfering in any way with the freedom of choice of carrier, by having the individual make a statutory declaration of his eligibility for subsidy, to the carrier of his choice. The carrier would then bill government on behalf of all subsidized residents to whom it had issued standard contracts.

We recommend that this latter method be adopted.

TYPE OF CONTRACT TO BE SUBSIDIZED

66. If the recommendations of our Association are accepted, the standard contract with benefits of Schedule A may be sold on either a basis of first dollar coverage or with a deductible and co-insurance. Without question, those fully subsidized should have first dollar coverage.

67. This issue is not so clear cut when considering those to be partially subsidized. A case could be made for the proposition that the citizen should be able to apply his subsidy toward the type of contract which would suit his personal approach to insurance. If he chose to use his subsidy to pay a greater proportion of the lower premium of the deductible type of contract, he would have some savings to pay the deductible and co-insurance requirements.

68. This proposition must be examined, however, in the light of Bill 163, and the reasons why government is proposing this type of legislation. It has been said repeatedly that a certain group of citizens do not seek medical services because they have no insurance or ready cash to pay for such services. Those requiring subsidy would likely make up the bulk of this group, and while theoretically they should have funds available if they use their subsidy to pay a greater proportion of the lower deductible type premium, the likelihood is that in practice they would not, and hence the economic barrier to medical services would not have been removed.

69. In a major or prolonged illness, the co-insurance feature of having to pay 20% of the cost above the deductible could prove to be a burden. This is true, particularly as insurance for drugs and other costs ancillary to medical services, if available, also carry deductible and/or co-insurance requirements.

70. There is one additional consideration and that is the availability of general practitioner services. Experience has shown that when lower income patients have the deductible and co-insurance type of contract, the general practitioner, in many cases, actually subsidizes the patient to the extent of the deductible and co-insurance. We believe the continuance of satisfactory medical services is dependent upon having general practitioner services readily available to all citizens. We would be concerned, therefore, if with the current and foreseeable shortage of general practitioners, the prevalence of insurance of this type in certain areas of the province where the majority of citizens required subsidy made it still more difficult to attract and retain general practitioners.

71. Casual consideration might lead one to suggest that in-hospital contracts might be subsidized in certain situations. We have found, on the basis of experience, that it is very difficult to transfer a patient from a hospital to a nursing home or his own home when he has only in-hospital benefits and limited financial resources.

72. In the light of these considerations, our Association recommends

THAT any subsidy be made available only for the purchase of the standard medical services insurance contract.

CARRIERS TO BE USED FOR THOSE SUBSIDIZED

73. (a) Totally Subsidized

We believe the carrier for those totally subsidized by government should be the Medical Welfare Plan, or a plan given some other name, administered by our Association.

74. We arrived at this opinion after examining the various possibilities available to government. One would be to use multiple carriers. This appeared to have disadvantages from the point of view of both government and those being subsidized. The classes of citizens outlined in Schedule C include many who are aged and incapacitated. This would make it difficult for them if the responsibility of finding a carrier, keeping their insurance in force, dealing with insurance forms and doctors' accounts, was left with them.

75. At the same time, this would place government in the position of having to pay varying premiums to different carriers, thus making it difficult to determine its liability for budget purposes.

76. These considerations made it appear reasonable for government to accept the responsibility of dealing with one insuring agency on behalf of this group.

77. One method available to government of insuring with one carrier would be to ask for tenders on the benefits of the standard medical services insurance contract for this group. This would place the contract with an indemnity company as they are the only ones which quote special rates for different groups.

78. This method would make it possible for government to determine its financial liability for budget purposes, but would not give those insured the protection given by the Medical Welfare Plan, where physicians agree to accept the payment as the full account for services rendered.

79. Another method available to government would be to insure this group with a service plan which has a uniform premium for all groups. This would fix government's financial liability and would give those insured more protection than with an indemnity plan because the majority of physicians have entered into participating physicians' agreements with service plans. However, not all physicians have, and a percentage of patients would not have the protection of those agreements.

80. Moreover, the totally subsidized group contains more than twice as many citizens over age 65 as in the general population, as well as many chronically ill (e.g., totally disabled.) Thus it is a very high cost group and the extra cost of insuring them would have to be spread back to all other subscribers through the pooling arrangement. While this would allow

government to pass on some of its financial responsibility by raising the premium of all other subscribers, we do not believe it wishes to, and we do not think it should do so.

81. Finally, the government could insure this group for the benefits of Schedule A through the Medical Welfare Plan or its counterpart administered by the Ontario Medical Association.

82. We favour this arrangement because the medical profession has had 28 years of experience in dealing with it for this group on a service basis; the administrative cost is low; it does not have to meet the usual requirements for insurers; it could be exempted from the provisions of the Act so that it would not have to offer standard contracts to other residents or be a member of Medical Carriers Incorporated.

83. In the light of these considerations, we recommend, on behalf of those totally subsidized:

1) THAT government insure the benefits of Schedule A on a basis of first dollar coverage.

2) THAT government make an arrangement with the Ontario Medical Association for the insurance of this group.

3) THAT this arrangement be outside of Medical Carriers Incorporated.

84. (b) Partially Subsidized

We believe that citizens who receive partial subsidy and thus have a

responsibility for the payment of a portion of the cost of their insurance, should have free choice of carrier.

85. It is true that our recommendation does not make it mandatory for all carriers to sell Schedule A on a basis of first dollar coverage. However, we are satisfied that those partially subsidized will not have any difficulty in finding a carrier which sells this type of policy. The freedom to choose a carrier allows the citizen the opportunity of taking his subsidy and buying his policy from the carrier which he feels, on the basis of service and price, will be most satisfactory.

IDENTIFICATION OF THOSE BEING SUBSIDIZED

86. The question as to whether subsidized patients should be identifiable by the doctors treating them deserves careful consideration. There are those who feel that identifying them makes them "second class" citizens. We are not in accord with this opinion. Moreover, we believe that it can redound to the subsidized patient's advantage if the doctor is aware of his economic circumstances. The doctor might be able to make special arrangements for care, and the profession, in rendering services to patients subsidized on the basis of need, would undertake, in general, not to bill above the practice in general or specialist schedule, as the case may be.

87. We recommend, therefore,

THAT all subsidized medical services insurance contracts bear some mark or code which will make it apparent to the doctor that the patient is in receipt of subsidy.

MUNICIPAL CONTRIBUTIONS - SECTION 4

88. Section 4 gives authority to a local municipality to purchase or contribute to the purchase of standard contracts for residents who receive municipal unemployment or other assistance or who are referred to under Section 54 of The Public Health Act. The section is merely permissive and exerts no compulsion on the municipality to provide this insurance for its needy residents.

89. Section 54 of The Public Health Act is under the heading of "Medical Care of Indigents." That section is mandatory in requiring every municipality to enter into an agreement with the medical officer of health or some other legally qualified medical practitioner for the care of persons suffering from injury or disease who, in the opinion of the head of the municipality or its welfare administrator, are unable through poverty to pay for attendance and who are not cared for in any hospital.

90. While the foregoing clearly imposes a duty on the municipality, it is our information that seldom, if ever, are the requirements of the said section met.

91. We are not recommending that the requirements of this section be met. In our opinion, its direction to a municipality to make one physician responsible for the medical services required by a group of unfortunate citizens and its limitation of these services to home and office care,

are so unrealistic in the light of the principles enunciated in Bill 163, that it should be repealed.

We recommend that this be done.

92. We believe, however, that the municipality has a definite financial responsibility for the medical services required by some of its residents. This concept has been accepted as it pertains to hospital services. The regulations under The Hospital Services Commission Act place an obligation on the municipality to either insure those needy persons for whom it is or might be responsible, or pay the statutory daily rate to the hospital to which they are admitted.

93. The Hospital Services Commission Act states:

> "38.(1) Where a resident who is not an insured person is admitted to a hospital and is at the time of admission, or later becomes, a person for whom a municipality or Ontario is responsible under the Public Hospitals Act, the Commission shall pay to the hospital an amount in respect of insured services received by the hospital indigent equal to the difference between the statutory rate payable under that Act and the per diem rate established for the hospital by the Commission.
>
> (2) A person who is a hospital indigent referred to in subsection 1 is entitled to receive insured services."

94. We are confident that the implementation of our recommendation for the determination of those requiring total or partial subsidy will meet the need of the majority of citizens. However, in any method, based on rough justice for ease of application, there is bound to be the occasional situation where a resident will not be able to take advantage of the opportunity to purchase a standard contract of medical services insurance because of particular financial circumstances.

95. We can see two situations where this might pertain. One, the resident who qualifies for partial subsidy, but cannot pay his portion of the premium. The other, the resident who, because his income exceeded his personal exemptions in the previous year, does not qualify for subsidy and in the meantime his economic circumstances have undergone such change as to make it financially impossible to purchase insurance.

96. In our opinion, the municipality, because of its knowledge of local circumstances, should be responsible for determining and meeting the need of these residents. This could be accomplished by incorporating in the proposed legislation, an obligation on the municipalities either to purchase or assist in the purchase of standard medical services insurance contracts for these residents, or to pay for the necessary medical services rendered to them.

97. We are not suggesting that the total cost involved in this recommendation should remain with the municipality. This would be a matter for arrangement with the other levels of government.

MEDICAL CARRIERS INCORPORATED - SECTION 8

98. This corporation is defined in clause (b) of section 1, and section 8 purports to deal with its functions. It is our considered opinion that the Bill should more specifically state the purpose and objects of the corporation rather than leaving this solely to the Letters Patent of incorporation. Further, the detailed provisions set forth in subsection (2) to (6) seem to be an unnecessary part of the Bill and could more properly be included in the Letters Patent or by-laws of the corporation.

99. We suggest that clause (b) of the Bill is probably unnecessary and might be repealed in view of our proposed rewording of section 8, which is detailed in Part II of our submission.

ADDITION OF PROVISION FOR ADVISORY COMMITTEE

100. The establishment of this Public Enquiry, made up of commissioners representative of insurers and the recipients and providers of medical services, is indicative of government's desire to have advice in matters of policy relating to medical services insurance.

101. We believe the legislation, proposed by this Enquiry, should make provision for a similar body to act as an adviser to the Minister relative to the operation of the initial legislation and whatever changes may be required to fulfill the purposes of Bill 163, "to make it possible for all residents of Ontario to obtain protection against the cost of medical and surgical care and services."

102. We will make a suggestion in Part II of our submission regarding the wording of a new section 8A, which will set out the composition and terms of reference of the Advisory Committee.

CANCELLATION OF STANDARD CONTRACTS

103. Under section 1 (e) and section 16 (a), the only grounds for cancellation of a standard contract are misrepresentation and non-payment of the subscription.

104. While not many in number, there are persons who presently misuse medical services coverage, i.e., they go repeatedly unnecessarily to the doctor or perhaps go to different doctors. When a person becomes entitled by law to certain contractual benefits, it becomes difficult for the practitioner to refuse his services, even if he concludes they are being misused. Where more than one practitioner is involved, the situation becomes more difficult to control.

105. It is the considered opinion of the Ontario Medical Association that some specific provision should be made to permit cancellation in cases of continued misuse. This would protect the other subscribers against having to share in the unwarranted costs associated with continued misuse. To protect the subscriber against unilateral action by a carrier, we are recommending that no carrier be permitted to cancel a contract for misuse without the authorization of the Advisory Committee.

106. Undoubtedly objection can be taken to vesting in a committee the authority of determination of a right. It may be argued that there should be some definition of misuse and that if a dispute arises, it should be left to the court to adjudicate thereon. There are two serious objections to this, viz.:

a) It is almost impossible to provide a clear definition that in itself might not produce doubt and unfairness; and

b) The expense and uncertainty would not justify resort to the courts.

107. A properly constituted committee would be more fitted to adjudicate on the question. If it were before a judge, he would require the calling of expert testimony.

108. The Act contemplates coverage available only to residents of the province - see definition in section 1 (n). There will be many occasions where persons who at the inception of the contract are residents but later cease to be. In view of the non-cancellable nature of the contracts contemplated, serious argument could arise if the subscriber continued to demand coverage although he was no longer an Ontario resident. .

109. It is advisable to permit a carrier to cancel a contract where the subscriber ceased to be a resident of the province. This concept of residence presents problems. It would be advisable to provide some definition of what constitutes prima facie evidence of change of residence to avoid unnecessary controversy.

110. To implement the above submissions with respect to cancellations, amendments to section 16 have been set out in Part II of our submission.

RATE STRUCTURE AND MAXIMUM PREMIUMS

111. Section 16 (b) sets out a two-rate structure and establishes maximum premiums. We believe a three-rate structure would prove to be more satisfactory. Experience has shown that the majority of residents over age 65 have but one dependent. Thus the establishment of a rate for a resident and one dependent at twice the single rate would give these residents a lower premium than the single family rate. We think this would be desirable.

112. The necessary amendments to section 16 are set out in Part II.

113. We are not recommending definitive maximum premiums as we feel this would be premature at this time. This function has been assigned to Medical Carriers Incorporated. In our opinion, realistic rates cannot be determined until the benefits of the schedules, the rate structure, and the date of implementation of the legislation have been decided.

ARBITRATION AS TO RATES

114. Section 18 deals with the subject of rate adjustments after the initial two-year period. As Medical Carriers Incorporated initiates the request for rate change and is composed of all carriers, it is the view of

the Association that it is illogical for classes of carriers in membership in that corporation to each name an arbitrator. That body should be entitled to name only one arbitrator. It is suggested that the second arbitrator be named by the Minister. The third arbitrator, who shall be chairman, shall be appointed by a judge of the Supreme Court.

OTHER INSURANCE

115. Section 20 (1), deals with overlapping insurance, i.e., where a subscriber has a standard contract and also another medical services contract not within the ambit of the Act. We see no reason for entirely denying a subscriber recourse to his standard contract because he has other insurance.

116. If benefits are payable under two contracts, they should contribute to the total extent to indemnify the insured. He has, in fact, paid two premiums.

117. To implement the foregoing, it would be necessary to re-draft subsection (1) of section 20.

FREEDOM OF CHOICE

118. While the Association is not unmindful that it is arguable that this provision is not absolutely necessary, it might allay some misgivings if a new section were enacted, reading as follows:

21A No carrier, by a medical services insurance contract, shall interfere with the right of an insured person to choose his own physician or impose an obligation upon a physician to treat any insured person.

MEDICAL EDUCATION

119. The decision of government, as outlined in Bill 163, to purchase or contribute to the purchase of standard medical services insurance contracts for those who require financial assistance, is bound to have some effect on medical education.

120. The greater the success of this piece of legislation, the fewer will be the number of residents who will occupy beds in teaching units simply because their financial resources give them little option to do otherwise.

121. This does not mean, necessarily, that fewer patients will choose to go there. It does mean that we are facing a transition period in medical education; a period which will require careful analysis not only by our medical schools but by the public and the medical profession, which are dependent upon them for the steady flow of medical graduates required to meet the needs of an expanding population.

122. Traditionally, those residents who occupied beds in a teaching unit or attended teaching outpatient clinics, have not been charged for the

medical services received. As the number of insured patients increased, the benefits of insurance were collected, not by the individual doctor, but by the teaching staff as a whole, and used for the purpose of furthering medical education.

123. Those responsible for medical education have realized for some time that there would have to be a break with tradition in order to recruit the number of teachers needed and require them to give a specified number of hours per week to a teaching program. The ability of patients to pay for the medical services, rendered by members of the teaching faculty, through their insurance, will merely hasten a change which was inevitable.

124. Our Association supports the view expressed by the medical faculties of our universities that benefits of medical insurance should accrue to members of medical faculties providing medical services in our university teaching hospitals.

125. This policy of charging patients for their medical care, while at the same time expecting them to be part of the teaching program, will place these teaching departments in the position of having to attract patients. This will require not only a continuance of high quality medical services, but surroundings and service comparable to that given patients who go to private physicians and occupy beds in private wings of our hospitals.

126. We have no concern about the quality of medical services. The high standard associated with teaching units will be maintained. We do believe, however, that the physical surroundings in both in-patient and out-patient departments will have to be modernized to make them attractive.

127. The long waiting periods, which have almost inevitably faced clinic patients, will have to be overcome by the addition of whatever number of medical and ancillary personnel is required to provide reasonably prompt service.

128. The need for additional medical schools is urgent. The same can be said for training schools for nurses and physio and occupational therapists. There is a shortage of hospital beds - critical in some areas such as Metropolitan Toronto. The facilities and staff required for an enlightened approach to the treatment of mental illness fall far short at the present time.

129. It might be said that all of these things have nothing to do with Bill 163. In a way that is true, and yet to insure medical services without giving thought to the means of providing them would be short-sighted indeed.

130. Our object is to draw attention to the fact that this proposed insurance legislation will not provide funds for medical teaching nor for any of the other shortages we have mentioned. These funds must come from other government sources. Preoccupation with insurance must not be allowed to impede progress in these other more vital areas.

SCHEDULE A

131. Benefits Provided by a Standard Medical Services Insurance Contract or a Standard Deductible Medical Services Insurance Contract

The wording in Bill 163 is as follows:

> "Necessary professional services of a physician wherever rendered, unless excepted under this Act or under this Schedule."

132. We have some disagreement with this wording as insurance cannot provide the "necessary professional services of a physician." It can, however, insure the expenses incurred when those services are rendered. We recommend that the wording of the benefits in Schedule A be as follows:

> SUBJECT TO ALL THE PROVISIONS OF THIS ACT, THE EXPENSES ACTUALLY INCURRED BY AN INSURED PERSON, FOR NECESSARY PROFESSIONAL SERVICES OF A PHYSICIAN, WHEREVER RENDERED, UNLESS EXCEPTED UNDER THIS ACT OR UNDER THIS SCHEDULE.

Exceptions

133. We wish to make recommendations regarding some of the exceptions.

134. 1. "Annual or periodic health examinations."

This exception is worthy of some consideration. Undoubtedly there will be differences of opinion about it. There are a few aspects to be

thought about. Bill 163 is an insurance Act. Insurance is designed to help pay for unexpected expenditures. Annual or periodic health examinations are not insurable items. They are items which can be budgeted for at less expense than through insurance.

135. Health examinations are difficult to define. They range from a history and physical examination and a few simple laboratory tests to the whole gamut of diagnostic tests. Rarely is disease discovered in a patient who has no signs or symptoms. The question then arises as to whether a doctor's time is not spent to greater advantage in examining patients with early signs or symptoms.

136. Health examinations in which no disease is found often give the patient a false sense of security. As a result, symptoms which appear shortly thereafter may be disregarded and the chance of cure lost thereby.

137. Insurance plans with this benefit have found that subscribers make little use of it. This is understandable when the patient is free to consult his physician at the first sign or symptom of ill health.

138. We recommend that this exception be retained but re-worded as follows:

ANY HEALTH EXAMINATION.

139. 2. "Services that a covered person is entitled to receive without charge."

140. We believe exceptions 2, 4 and 10 can be combined to advantage and suggest the following wording:

SERVICES THAT A COVERED PERSON RECEIVES, WHICH SERVICES HE IS ENTITLED TO RECEIVE WITHOUT CHARGE, INCLUDING:

i) SERVICES RECEIVED WHEN HE IS A PATIENT IN ANY TYPE OF INSTITUTION OR SPECIAL HOSPITAL WHEN SUCH SERVICES ARE PAID FOR BY THE SAID INSTITUTION OR SPECIAL HOSPITAL;

ii) SERVICES OBTAINED WITHOUT CHARGE BY LAW OR FOR WHICH THERE IS NO ACTUAL CHARGE MADE TO HIM FOR ANY OTHER REASON;

iii) SERVICES REQUIRED IN RESPECT OF AN ACCIDENT OR SICKNESS COVERED BY ANY WORKMEN'S COMPENSATION LAW OR SIMILAR LEGISLATION;

iv) SERVICES FOR WHICH NO CHARGE WOULD BE MADE IN THE ABSENCE OF INSURANCE.

141. 3. "Laboratory and other diagnostic procedures rendered as hospital services to the extent that these are provided for under the plan of hospital care insurance under the Hospital Services Commission Act; dental services; ambulance services; nursing services; dressings and cast materials; use of operating, plaster or fracture rooms; services of government or commercial laboratories; drugs, vaccines, biological sera or extracts or their synthetic

substitutes; eye glasses; special appliances; oxygen; physical therapy and other similar treatments."

142. We wish to make some comments about this section. The first part deals with diagnostic services covered under the Hospital Services Commission Act. These medical services include radiology, clinical pathology, electrocardiography and electroencephalography.

143. The extent of these services provided for in regulations, at the inception of the government hospitalization insurance program, have been extended by amendments to the regulations under the Hospital Services Commission Act. They could be extended further and could result in encroachment on the provision of the proposed Medical Services Insurance Act.

144. We believe that the insurance of all medical services should be brought under the provisions of a Medical Services Insurance Act. We realize that, at the present time, there might be some reluctance on the part of government to transfer those medical services which are insured now under the Hospital Services Commission Act because of the contribution being received from the federal government to help pay for them. Nevertheless, we recommend

THAT this policy be established now and be implemented as soon as possible.

We would be pleased to work with government in studying ways and means of achieving this goal. In the meantime, we recommend

THAT no further encroachment be allowed by further amendment to the regulations under the Hospital Services Commission Act.

145. Drugs

We agree that drugs should be an exception under a Medical Services Insurance Act. At the same time, we have some concern about the present arrangements, or lack of them, for the provision of drugs to patients who have been accepted by government as being in needy circumstances.

146. A review of the present situation made by our Pharmacy Committee during the past year indicated varying arrangements whereby persons in needy circumstances obtained necessary drugs. These included:

1) The municipality may pay for drugs from its own funds.

2) The municipality may enter into an agreement with the provincial Department of Public Welfare whereby certain municipal and provincial funds are made available to provide for unusual expenditures, including drugs - the limit being $20. per person per month.

3) The patient may pay for his drugs in whole or in part, from his social assistance allowance.

4) Drugs may be provided free of charge by physicians, retail pharmacists, pharmaceutical manufacturers, service clubs, or other voluntary associations.

5) Patients with particular diseases, e.g., cancer, tuberculosis, diabetes, may be provided with drugs for treatment of the specific disease.

147. The Committee also drew attention to the problem of patients with marginal incomes, (those who would be eligible for partial subsidy to purchase medical services insurance by our method of determination.) It was felt there were prescriptions given by physicians which were never presented or filled by the pharmacist because of the cost factor. The extent of this problem was difficult to assess.

148. We recommend, therefore,

THAT government give early consideration to a plan whereby subsidized patients will be assured of getting necessary drugs.

149. 5. "Services with respect to conditions that do not interfere with the covered person's bodily functions, or with respect to treatment for cosmetic purposes."

150. The wording of this exception is unclear and so difficult of interpretation. In our opinion all services required for the treatment of conditions affecting the physical or mental health of an insured person should be covered. By the same token, requests for the treatment of conditions which have no effect on either should be eliminated.

151. We believe the following wording accomplishes what is desired and we so recommend:

SERVICES WITH RESPECT TO TREATMENT FOR PURELY COSMETIC PURPOSES.

152. 6. "Newborn infant care rendered by the physician delivering the infant." We do not believe there was an intention to eliminate newborn infant care rendered by the physician delivering the infant. While the present fee schedule does not include a charge for such care, subsequent ones may do so. We recommend

DELETION of this exception as we believe it should be a benefit.

153. 7. "Mileage."

This would be more properly worded:

EXPENSES FOR TRAVELLING TIME AND MILEAGE.

154. 9. "Any services or examinations for the purpose of

a) an application for insurance or under a requirement for keeping insurance in force;

b) an application for admission to or continuance at or in a school, college, university, camp or an association;

c) employment, or the continuance of employment, or pursuant to the request of an employer or other person in authority;

d) a passport, visa or other similar document."

We recommend that there be added a new subsection (e):

e) ANY OTHER SIMILAR EXAMINATIONS REQUIRED OTHER THAN FOR THE HEALTH OF THE PERSON COVERED.

This exception, as amended, might be combined with exception #1.

155. 11. "Refractions for safety glasses."

It appears as if the intent was to eliminate refractions requested by employees of industry where the employer required them to wear safety glasses. In our opinion this is covered in exception #9 (c).

156. We believe that refractions per se should be made an exception. They are inexpensive and are a matter of election on the part of an insured person. This could be accomplished by the following wording:

EXAMINATION OF THE EYES BY REFRACTION FOR THE FITTING OF EYE GLASSES.

Additional Exception

157. We recommend that

PSYCHOTHERAPY TREATMENTS IN EXCESS OF 50 HOURS PER ANNUM

be an exception under this schedule. We believe that standard plans with the benefits of Schedule A should include all psychiatric services rendered by physicians in the private practice of medicine within the limitations of this proposed exception.

158. It is our understanding that 50 hours of psychotherapy per annum is sufficient for the treatment of the majority of mental illnesses. At the same time it will limit the liability of the carriers for those cases which are treated by analysis. This appears to be reasonable as apparently patient participation in the cost is recommended by those psychiatrists using this form of therapy.

SCHEDULE B

159. We are in agreement with having a Schedule B but have some suggestions for modification of benefits and wording. Our concern about Schedule B is because all its benefits are limited to patients admitted to hospital. This will bring undue pressure on physicians to admit patients to hospital, whose medical requirements would not justify admission, simply because it would be to the patient's financial advantage to be so admitted. While it may be said that the doctor should make the decision as to whether a patient requires admission or not, the doctor's chief concern is his patient and his decision will be influenced by what is advantageous to his patient.

160. We believe there is a place for a standard contract, with its provisions of non-cancellability, a maximum premium, and universal availability, which has lesser benefits than Schedule A and hence a smaller premium. There are those who desire this type of coverage and we should make it available in a form which will provide good protection against the larger items of medical expenses.

161. On this basis, there are two out-of-hospital benefits which should be added to Schedule B. One is diagnostic services and the other referred consultations. These items are not only among the more costly out-of-hospital services, but are the chief reason for patients demanding admission when they have insurance limited to in-hospital benefits.

162. These items require definition. Referred consultations are opinions of other doctors requested by the attending physician. Diagnostic services are more difficult to define accurately. For the purpose of Schedule B, they might be limited to those diagnostic services covered by the Ontario Hospital Services Commission for in-hospital patients, namely, all radiological and pathological services, electrocardiograms and electroencephalograms.

163. The question arises as to whether there should be any upper limit of financial liability for these services. In our opinion there should not be for referred consultations. We believe a reasonable degree of protection would be afforded, however, if the liability for diagnostic services was limited to $50. per individual, and $75. per family contract per year. This limitation, by discouraging unwarranted use, would help to stabilize the premium at a more appropriate level.

164. Therefore, we recommend that Schedule B be worded as follows:

> SUBJECT TO ALL THE PROVISIONS OF THIS ACT, THE EXPENSES ACTUALLY INCURRED BY AN INSURED PERSON, FOR NECESSARY PROFESSIONAL SERVICES OF A PHYSICIAN TO AN ADMITTED BED PATIENT IN A HOSPITAL APPROVED FOR THE PURPOSES OF THE PLAN OF HOSPITAL CARE INSURANCE UNDER THE HOSPITAL SERVICES COMMISSION ACT, UNLESS EXCEPTED UNDER THIS ACT OR UNDER SCHEDULE A,

and

THE EXPENSES ACTUALLY INCURRED BY AN INSURED PERSON, FOR THE FOLLOWING NECESSARY PROFESSIONAL SERVICES OF A PHYSICIAN RENDERED TO A PATIENT WHO IS NOT AN ADMITTED BED PATIENT IN A HOSPITAL APPROVED FOR THE PURPOSES OF THE PLAN OF HOSPITAL CARE INSURANCE UNDER THE HOSPITAL SERVICES COMMISSION ACT:

1. REFERRED CONSULTATIONS.
2. THE DIAGNOSTIC SERVICES OF CLINICAL PATHOLOGY, RADIOLOGY, ELECTROCARDIOGRAPHY AND ELECTROENCEPHALOGRAPHY TO A MAXIMUM OF $50. PER INDIVIDUAL PER YEAR OR $75. PER FAMILY PER YEAR.

SCHEDULE C

165. We are in agreement with Schedule C as written.

NEW SCHEDULE

166. We have recommended that the classes of persons eligible for partial subsidy be set out in a schedule.

PART II

SCOPE OF PART II

167. The following paragraphs set out certain suggested amendments to Bill 163 discussed in Part I, but they also include a number of technical amendments that appear to be required.

168. Section 1 (a) - Definition of "benefit"

Insert after "to" in the first line, the words "or on behalf of" so that it would read:

> "(a) "benefit" means a payment made to or on behalf of a covered person for medical or surgical care or services or the performance of such care or services for a covered person under a medical services insurance contract."

169. While under insurance contracts the payment of the benefits will be made to the covered person, in the case of P. S. I. and other carriers, the payment is made to the physician on behalf of the covered person.

170. Section 1 (c) - Definition of "covered person"

While the word "cover" or "covered" is often used by insurers to describe a person who, or an object that, is insured, a more enlightening word is "insured." Accordingly, it is suggested that (c) read as follows:

"(c) "insured person" means a person who is covered by medical services insurance."

171. If the expression "insured person" is substituted for "covered person" then clauses (a) and (e) of section 1 and subsections (3) and (4) of section 19 will have to be changed.

172. Section 1 (d) - Definition of "dependent"

Regulation 1 (3) (d) of the Ontario Hospital Services Commission Regulations defines "dependent" as follows:

"dependent" means a resident who is,

i) the spouse of a head of a family, or

ii) a child of the head of a family who is dependent for support upon the head of the family and who is,

a. under the age of nineteen years and unmarried, or

b. nineteen years of age or over, mentally or physically infirm and dependent for support upon the head of the family or upon the spouse of the head of the family, before his nineteenth birthday, but does not include the spouse of any such child;

173. It is perhaps advisable to follow the same or substantially the same definition. The exclusionary words "but does not include the spouse of any such child" appear to be unnecessary. Clause (ii) b. perhaps might be reworded as follows:

"b. nineteen years of age or over, mentally or physically infirm, and dependent for support upon the head of the family or upon the spouse of the head of the family, before his nineteenth birthday and who continues from that age to be so dependent by reason of his infirmity."

174. The reason for the latter wording is to prevent any argument arising in the case of a child who attains the age of nineteen years and say, at twenty-one years, becomes dependent because of a mental or physical infirmity then occurring.

175. Section 1 (e) - Definition of "guaranteed renewable"

This expression appears to have been used only once in the Act and that in section 5 (a) of the Bill. It is questionable drafting practice to define a phrase used only once in the Act unless the definition deals with a cumbersome phrase. If section 16A suggested in paragraph 190 is adopted then the definition of the phrase is perhaps unnecessary.

176. Section 1 (g) - Definition of "hospital"

As this definition is only used in Schedule B this might be deleted from section 1.

177. Section 1 (i) - Definition of "medical services insurance"

This definition is important for the purposes of the introductory wording of section 5 and also for the purposes of sections 7 and 8 when read with the definitions in section 1 (b) and section 1 (h).

178. It is suggested that the latter part of this definition should read:

"but does not include any limited or incidental coverage for medical and surgical expenses provided in a contract of motor vehicle liability, employer's liability, public liability, and workmen's compensation insurance."

179. Section 1 (n) - Definition of "resident"

In the corresponding definition in section 1 (3) (p) of the Ontario Hospital Services Commission Regulations the words

"but does not include a tourist, a transient or visitor to Ontario"

are found at the end of the definition. While they may be unnecessary they may assist in interpretation in certain cases.

180. Section 1 (o) - Definition of "standard in-hospital....contract"

It is suggested that this read as follows:

"(o) "standard in-hospital medical services insurance contract" means a contract that provides the benefits set forth in Schedule B on a basis of first dollar indemnity."

181. Section 1 (p) - Definition of "standard .....contract"

It is suggested that this read as follows:

"(p) "standard medical services insurance contract" means a contract that provides the benefits set forth in Schedule A on a basis of first dollar indemnity."

182. Section 1 (pp) - Definition of "standard deductible.....contract"

"(pp) "standard deductible medical services insurance contract" means a contract that provides the benefits set forth in Schedule A subject to a deductible of $25. per annum ($50. per annum per family,) and subject to a co-insurance requirement that the subscriber bear 20% of each claim for benefits above the deductible."

A perusal of this new definition will show the reason for rewording of the definitions in (o) and (p) above.

183. Sections 9, 11, 12, 13, 14, 15, 17, 20 and 22

If the three types of contract are to be recognized, then appropriate references to these will be required in the above sections.

184. Section 5

To implement recommendations made in Part I, paras. 20-27, we suggest that this section be reworded as follows:

"5. (1) No carrier licensed under the Insurance Act or registered under the Prepaid Hospital and Medical Services Act shall sell or provide or offer to sell or provide any form of medical services insurance unless

(a) it offers for sale and issues,

i) standard in-hospital medical services insurance contracts; and

ii) standard medical services insurance contracts; or

iii) standard deductible medical services insurance contracts,

to residents who are not dependents, other than a spouse, and who apply and pay the subscription therefor; and

(b) is a member in good standing of Medical Carriers Incorporated.

(2) Where a carrier is not required or entitled to be licensed under the Insurance Act or registered under the Prepaid Hospital and Medical Services Act, it shall nevertheless become and remain a member in good standing of Medical Carriers Incorporated."

185. Section 6

To implement the recommendation made in Part I, paras. 17-19, we suggest that this section be reworded as follows:

"6. Where a carrier issues a standard medical services insurance contract, or a standard deductible medical services insurance contract, or a standard in-hospital medical services insurance contract, it may, by rider to the contract for an additional stated premium and not otherwise, provide benefits greater than those set forth in Schedules A and B."

186. Section 7

To implement the recommendation made in Part I, paras. 28-30, we suggest that subsection (2) be deleted and the following substituted:

"(2) The Minister, on the recommendation of the Advisory Committee, may suspend or cancel the licence of a carrier if he deems that it is not operating in the public interest or if it contravenes any provision of this Act.

(3) Every carrier that carries on business as such without a licence under this Act is guilty of an offence and on summary conviction is liable to a fine of not more than $..... for each day upon which it so carries on."

187. Section 8

To implement the recommendations made in Part I, paras. 98 and 99, we suggest that this section be reworded as follows:

"8. (1) There shall be incorporated a non-profit corporation, under Part III of The Corporations Act, to be known as "Medical Carriers Incorporated."

(2) The corporation shall make regulations establishing the qualifications necessary for membership of carriers in the corporation.

(3) The corporation shall establish and administer a pooling arrangement amongst its members whereby the cost of providing standard medical services insurance contracts

(187) for persons who are over 65 years of age and for persons who are suffering from injury or disease at the time of application for the contract shall be borne equitably by all carriers members of the corporation. Nothing herein shall preclude the exemption of any carrier from pooling pursuant to a by-law provision in that behalf.

(4) The corporation shall annually assess its members for moneys required for the operation of the corporation including the costs of the pooling referred to in subsection (3).

(5) The corporation, by regulation, shall establish a procedure for determining the total annual assessment and the proportions to be borne by each member of the assessment and shall establish a procedure for arbitration of any dispute arising from the proportion of the assessment imposed upon any member.

(6) The corporation shall exercise the powers granted to it by section 11 to fix open enrolment periods, by section 15 to prescribe the late enrolment fee, and by section 18 with respect to adjustment of maximum subscriptions.

(7) The corporation may make regulations binding upon its members relating to keeping of statistical data and making returns thereof to the corporation.

(187) (8) The corporation shall have and exercise such other powers and authority as are necessary for the carrying out of its objects, including matters relating to the technical administration of the standard contracts.

(9) No by-law made under subsections (2), (3), or (5) shall be binding until approved by the Minister on the recommendation of the Advisory Committee."

188. Section 8A

To implement the recommendation made in Part I, paras. 100 to 102, we suggest that a new section be inserted reading as follows:

"8A (1) There shall be established an Advisory Committee consisting of 9 members, three of whom shall be appointed by the Minister as representing the public, one only of whom should be from the Civil Service; 3 of whom shall be appointed by Medical Carriers Incorporated as representing the carriers, and 3 of whom shall be appointed by the Ontario Medical Association as representing physicians.

(2) Each person making the three appointments referred to in subsection (1) may, in addition, appoint three alternatives, any of whom may act in place of a member appointed by that person.

(188) (3) An appointment under subsections (1) and (2) shall be for a term of one year but any member is eligible for reappointment.

(4) Where the term of a member expires, he continues to be a member until his successor is appointed.

(5) Where a member is unable for any reason to attend a meeting of the committee or a subcommittee thereof, the member may designate one of the alternatives to act in his place, or in the event of the absence or inability of that member to make the designation, this may be made by the person making the appointment.

(6) Any vacancy occurring in the committee may be filled for the remainder of the term of the member whose place has been vacated by the person making the original appointment.

(7) The Minister shall call the initial meeting, at which time the committee shall elect a chairman and a vice-chairman. The Minister may appoint a secretary to assist the committee and keep its records.

(8) The Committee, with the approval of the Minister, may establish rules respecting the delegation of certain duties of the Committee to subcommittees, the calling of meetings and the procedure thereat and generally for carrying out the duties imposed upon it.

(188) (9) It shall be the duty of the committee

a) to advise the Minister with respect to suspension or revocation of licence;

b) to advise the Minister with respect to by-laws of Medical Carriers Incorporated submitted for his approval;

c) to require Medical Carriers Incorporated to make to it such reports as it may require;

d) to adjudicate upon complaints between subscribers and carriers, and between physicians and carriers;

e) to authorize carriers to cancel a contract for the reasons set forth in clauses (c) and (d) of subsection (1) of section 16A;

f) to keep under review the Act and its operation and to make to the Minister such recommendations with respect to regulations and with respect to amendments to the Act deemed to be required."

189. Sections 16 and 16A

To implement our recommendations made in Part I, paras. 103 to 113, we suggest that section 16 be reworded as follows:

(189) "16. Where a standard medical services insurance contract, standard deductible medical services insurance contract or a standard in-hospital medical services insurance contract is issued and the subscription paid therefor during the initial open enrolment period, it shall, for a period of two years from the day on which this Act comes into force, require a subscription not to exceed the maximum monthly subscription rates as follows:

	Standard Medical Services Insurance Contract	Standard Deductible Medical Services Insurance Contract	Standard In-Hospital Medical Services Insurance Contract
1. Resident	X	Y	Z
2. Resident and one dependent	2X	2Y	2Z
3. Resident and more than one dependent	2 1/2X	2 1/2Y	2 1/2Z

190. And the enactment of a new section to read as follows:

"16A. (1) No standard medical services insurance contract, no standard deductible medical services insurance contract, and no standard in-hospital medical services insurance contract shall, for a period of two years from the day on which this Act comes into force, be terminated, and thereafter, unless section 19 is invoked, by a carrier, except for

(190) a) misrepresentation or fraud; or

b) non-payment of the subscription; or

c) continued misuse of the services for which benefits are provided; or

d) the insured person ceasing to be a resident of Ontario.

(2) No cancellation for a cause set forth in clause (c) or (d) of subsection (1) shall be made by a carrier without the authorization of the Advisory Committee and that authorization shall be final and binding, subject to a right of appeal to a judge of the Supreme Court of Ontario."

191. Section 17

To implement the recommendation set out in Part I, paras. 31 to 40, we suggest that this section be reworded as follows:

"17. (1) The maximum amounts of benefits payable under a standard medical services insurance contract or a standard deductible medical services insurance contract or a standard in-hospital medical services insurance contract during the two-year period specified in section 16, shall be those amounts set forth in the Ontario Medical Association's schedule of fees in effect on the day this Act came into force, and after that period, those amounts set forth in the Ontario Medical Association's then current schedule of fees, unless the carrier and the majority of physicians who submit accounts regularly to that carrier,

(191) by written agreement applying generally to all subscribers of the carrier and to all benefits, agreed upon lesser amounts; and where a carrier has such agreements with physicians, the lesser amounts shall apply only to all benefits payable by that carrier for the services of those physicians.

(2) The amount of the benefits referred to in subsection (1) shall be the fees set forth in the schedule for practice in general unless

a) there has been a referral of the insured person to a certified specialist by another physician; or

b) there is no fee set forth in the schedule for practice in general,

and in these cases the fees set forth in the schedule for certified specialist shall apply.

(3) In this section "certified specialist" and "referral" shall have the meanings ascribed to them in the preamble to the schedule of fees."

192. Section 18 (2)

To implement the recommendation set out in Part I, para. 114, we suggest that this subsection be reworded as follows:

"(2) If the Superintendent does not within thirty days of the date of application by Medical Carriers Incorporated, consent to the adjustment of the maximum subscription rate, the

matter shall be referred for decision to a board of three arbitrators, one to be named by Medical Carriers Incorporated, one to be named by the Minister and one to be named by a judge of the Supreme Court upon application of the other two arbitrators, who shall be chairman."

193. Section 21

To implement recommendations made in Part I, paras. 41 to 49, relating to classes of persons falling within section 3 (b) of the Bill, it will be necessary to delete clause (a) of section 21, and to establish a new schedule specifying the classes of persons involved and dealing with the subsidy and the procedure for payment thereof.

194. Section 21A

The text of this section recommended in Part I, is set forth in paragraph 118 of that Part. To repeat, this reads as follows:

"21A No carrier, by a medical services insurance contract, shall interfere with the right of an insured person to choose his own physician or impose an obligation upon a physician to treat any insured person."

195. Section 23

While perhaps some provision similar to section 23 of the Bill may be necessary, it is now apparent that provisions of the Insurance Act and the Prepaid Hospital and Medical Services Act will be affected.

Some examination of these provisions should be made and a more precise statement made. Merely by way of example, it should be pointed out that certain provisions of the Accident and Sickness Part of the Insurance Act will be modified in respect of standard medical insurance contracts.

THE ONTARIO MEDICAL WELFARE PLAN

196. The number of unemployed grew steadily in the depression years following 1929, and the economic problem of many citizens, including doctors, and many municipalities, reached a state of emergency.

197. The Ontario Provincial Government sensed that a medical services program in some form was needed for the families on relief. In the autumn of 1932, the Provincial Government, by Order-in-Council, offered to pay two-thirds of the cost of medical relief, but little advantage was taken of this offer since few municipalities could make up the remaining one-third. This scheme ended in failure, and as a result full responsibility for medical relief was turned back to the financially poor municipalities.

198. The Ontario Medical Association, in an effort to solve a problem which appeared to be getting more serious month by month, offered to arrange a medical services program for all relief recipients in the province on the basis of 25¢ per person per month. This offer was accepted by the Ontario Government and on February 12, 1935, the then Minister of Public Welfare for Ontario, announced a program which would provide funds to assure medical benefits for destitute persons. On March 1, 1935, the Ontario Medical Association agreed to organize and administer a medical welfare

plan and to provide medical services consisting of home and office care and a limited number of drugs. These services were to be available to all recipients of relief in the province.

199. Since that time, the Medical Welfare Plan has extended its coverage to other groups. In 1942, recipients of Old Age Pensions, Blind Pensions and Mothers' Allowances were added to the list of participants. On January 1, 1952, the Old Age Assistance Act came into operation and this group of persons (65 to 69 years of age) was included. Effective July 1, 1952, recipients of the Disabled Persons' Allowance were added and in October 1959, a small group under the Rehabilitation Services Act became eligible. As of June 1963, an additional group, those in receipt of Widows and Unmarried Women's Allowances, came under the plan. The latter group, while constituting a new category, actually come under the regulations of the General Welfare Assistance Act.

200. On the basis of negotiation from time to time, the monthly rate provided by the Ontario Government to the Ontario Medical Association for the operation of the Plan has been revised upward following the cost of medical care which has increased in common with other services. The first contract with government, February 1935, was set at 25¢ per person per month, for all recipients. As of April 1935, this was altered to 50¢ a month for Northern Ontario and continued at 25¢ a month for Southern Ontario. In February 1937, a revision increased the amount for Southern Ontario to 35¢ per month.

201. On April 1, 1944, a further change provided 71¢ for Northern Ontario and 56¢ for Southern Ontario, per month. Toward the end of 1948 the contract stipulated 83¢ per month for all eligible recipients in the province. Again in December 1952, the amount was raised to $1.05 per capita and the last contract negotiated provided $1.25 per month, effective October 1, 1959.

202. At July 1, 1963, the Medical Welfare Plan listed eligible persons as follows:

Old Age Security	55,932
Old Age Assistance	20,000
Blind Persons' Allowance	1,301
Disabled Persons' Allowance	13,569
Mothers' Allowance	24,081
Rehabilitation Services Allowance	167
Widows and Unmarried Women's Allowance	916
Dependent Fathers - G. W. A.	13,007
General Welfare Assistance (Relief)	88,055
TOTAL:	217,028

203. The monthly case load varies and over the last twelve month period, (August 1962 to July 1963), registered a high of 243,739, (January 1963), and a low of 205,624 for September 1962. The monthly average was 222,000.

The fluctuation has been due principally to the rise and fall in the number of recipients in the General Welfare Assistance (Relief) category.

IDENTIFICATION OF PARTICIPANTS

204. Individual persons or family heads on General Welfare Assistance (Relief) are supplied with a medical identification voucher each month which should be presented to the doctor when medical services are required. These vouchers are issued by welfare officers in each municipality and are supplied free to the municipality through the Medical Welfare Plan.

205. The vouchers are in duplicate and list the total number in the family who are eligible to receive assistance during the month or part thereof. One copy of the voucher is given to the recipient and the other is retained by the municipality until the end of the month at which time it is forwarded to the Medical Welfare Plan. In the case of all other recipients, e.g., Old Age Security, Old Age Assistance, Blind Persons, Mothers' Allowance, etc., permanent numbered identification cards are issued directly from the Medical Welfare Plan office.

206. Recipients of allowances have individual cards, while Mothers' Allowance cards include the mother, eligible children and, if applicable, the husband. These identification cards are valid throughout the province

as long as the participant is listed as a qualifying recipient by the Ontario Department of Public Welfare.

207. Under the regulations of the Medical Welfare Plan, participants have a free choice of any practitioner, and in like manner, the physician has the right to choose his patients.

208. Under the Medical Welfare Plan, physicians provide home and office service and referred consultations on request of the family physician. In cases where a specialist gives continuing care, he is paid at the same rate as the general practitioner. The Plan provides payment for minor surgical and therapeutic procedures normally performed in the doctor's office or the patient's home. Provision is made for pre and post natal care and for delivery in the home.

209. In the rural areas, there is a mileage rate allowed on the basis of the number of miles, one way, from the doctor's office to the patient's home.

210. A doctor renders his accounts in accordance with our schedule of fees and the proportion paid by the Plan varies from month to month. It depends upon the amount of service required by the participants in relation to the fixed income received from the Department of Public Welfare. The attached table compares the years 1957, to 1962.

211. In the early days of the Plan, doctors provided free of charge, medication consisting of 32 drugs and mixtures of a limited nature. As time went on,

this requirement was dropped from the regulation as only a small percentage of doctors were in the habit of stocking and dispensing drugs. The regulation at the present time asks that a doctor provide emergency drugs on the occasion of the first visit only, without charge to either the patient or the Plan.

ADMINISTRATION

212. In essence, the Medical Welfare Plan is an agreement between the Department of Public Welfare and the Ontario Medical Association. Under this contract, the Association undertakes the administration of the Plan and this is carried out at the offices of the Association.

213. Matters of general policy are the responsibility of the Board of Directors and Council of the Association. The Executive Committee acts as a management committee, and assumes responsibility for the day to day operation of the Plan.

MEDICAL WELFARE PLAN
1957 - 1962

Monthly Averages: Participants, Funds, Accounts, Payments to Doctors, Operational Costs - Based on 12 months' experience

	1957	1958	1959	1960	1961	1962
INCOME						
Participants	160,640	191,367	202,095	209,663	223,692	220,295
Income per Participant	1.05	1.05	1.25**	1.25	1.25	1.25
Receipts from Ontario Department of Public Welfare	168,672.00	200,934.00	222,154.15	261,290.85	279,615.10	275,369.08
MEDICAL SERVICES						
Accounts Submitted	33,354	37,442	40,039	42,274	45,495	45,747
Office Calls	31,151	35,786	38,567	42,503	46,994	48,082
Home Calls	28,524	28,975	28,957	28,428	27,315	24,644
Special Services	4,656	5,617	5,962	6,117	6,744	7,214
Mileage	7,155.00	6,695.00	6,302.00	6,032.00	5,694.00	4,891.00
Value of Services (Rendered Fees)*	252,619.00	281,960.00	297,503.00	312,321.00	330,615.00	352,895.00***
Value of Services per Participant	1.57	1.47	1.47	1.49	1.48	1.60
Amount paid to Doctors	173,233.00	184,724.00	203,605.00	246,047.00	261,240.00	261,513.00
Amount paid per Participant	1.08	0.97	1.01	1.18	1.17	1.19
Payment to Doctors per dollar of Rendered Fee	0.69	0.66	0.68	0.79	0.78	0.74
ADMINISTRATION						
Administration Costs	11,164.00	12,710.00	13,629.00	14,434.00	16,340.00	17,146.00
Administration Cost in Relation to Income	6.6%	6.3%	6.1%	5.5%	5.8%	6.2%

*Rendered Fee: 1955 Schedule with Amendments to 1958

** 9 months at 1.05
3 months at 1.25

***Rendered Fee 1962 Schedule with Current Amendments